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Society Reports.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF CINCINNATI.

Stated Meeting, October 11, 1883.

The President, Dr. J. Trush, in the Chair.

Hematoma Vulvæ.

Dr. W. H. Wenning prefaced the report of a case of hematoma or thrombus vulvæ with the statement that it had been his good fortune in a comparatively short time to meet with three cases of affections of the external female genitals, all of which were of interest and two of them rather rare. The first was one of hypertrophy of the labia minora, reported before the Cincinnati Obstetrical Society at the meeting of April 12th, 1883 (1), the second was one of enormous fungoid vegetations on the labia and anus, which growths were successfully removed by Paquelin's thermo-cautery, and the third and most recent case was a hematoma or thrombus vulvæ, the subject of this sketch, with the following clinical history:

"Mrs. S., aged 24 years, married, a woman in robust health, the mother of one living child, was in her third pregnancy, in the ninth month of gestation; she had one miscarriage about one year ago. On the 19th of August, 1883, she visited her mother, who lived at some distance from her own residence. While there she had occasion to urinate, but she had scarcely sat down on a vessel when she suddenly screamed as if in great pain, stating that something had given way. Her mother, thinking that the waters had broken, as she knew that her daughter would soon be confined, hastened her to bed and sent for a midwife. When the latter arrived she examined the woman and found an unusual swelling about the genital parts; she told the mother 'that the external ligaments of the womb had given way,' and as she did not know what to do advised her to send for a physician at once. As I had attended the patient just a short time previous for an attack of cholera morbus I was summoned immediately. On my arrival, which was about eight o'clock in the evening, I found the patient lying on her back with her limbs drawn up and widely separated from each other, and apparently suffering

1 See Obstetric Gazette, June, 1883.

great pain. When I proceeded to make an examination I found a large swelling situated at the right labium, which was involved in its whole length, extending from the anterior to the posterior commissure. The tumor though very tense was elastic to the touch, giving the sensation of a thin membrane largely distended with fluid. The slightest pressure—yea, the mere touch—caused most excruciating pain, and on this account it was with great difficulty that I was enabled to pass my finger around the tumor, into the vagina and to the os uteri. From this examination I was satisfied that neither vagina, bladder nor rectum was involved in this protrusion, and came to the conclusion that this sudden swelling was owing to the rupture of a bloodvessel, the contents of which were rapidly effused into the loose cellular tissue of the labium of that side, thus forming a sanguineous tumor, or, as it is technically called, a hematoma or thrombus vulvæ. In order, however, to aid the sense of touch by that of sight, I examined the swelling more closely by means of the light of a lamp, when I found it as above described, nearly the size of a fist but somewhat pear-shaped in form, with the point directed towards the perineum (the latter was, however, not involved), of a dark purple color and very smooth and glistening appearance. The left labium and nympha were normal, but the right nympha was lost in the tumor, forming one body with the large labium of that side.

On inquiry I learnt that the patient was daily expecting her confinement and, according to her calculations, she looked forward to this event to the following Thursday—four days from the occurrence of this accident. From my own examination and the description of the pains given by the patient herself I was satisfied that labor pains had not yet set in. As the descent or pressure of the presenting part of the child, the most common cause of thrombus in pregnancy, could therefore not be the cause of rupture in this instance I was most curious to ascertain the true cause. In spite of close interrogation I could elicit no history of a blow or fall or any other traumatism, but was told by the patient that for the last few weeks she had felt very uncomfortable about the vulvar region, and that she had detected the presence of a cord-like projection in this place for some time prior to the accident; from which I concluded that this was a varicose vein which burst in consequence of some effort on the part of the patient, probably owing to a strain while she was trying to pass her water. Well recognizing the danger of hemorrhage should I attempt to open this sac, not to speak of the possibility of subsequent septicemia should labor soon set in, I contented myself with ordinary astringent and anodyne applications of lead water and opium, besides the internal administration of morphine to relieve pain and quiet the patient. On account of the extreme sensitiveness of the parts neither ice applications nor compression would be tolerated.

On the next (Monday) morning I found the tumor, though still very

large, not quite so tense and painful, and the patient also a little more comfortable. She had, however, the greatest dread lest labor pains should set in and the outcoming head would burst the tumor, an apprehension, which, I must confess, I also shared. She therefore implored me to relieve her as soon as possible, so that the tumor might be gone when the hour of labor should arrive. I comforted her by telling her that this swelling would gradually subside and I hoped that it would disappear before that time.

On Tuesday the tumor had subsided somewhat more, and the patient was also correspondingly still more comfortable. The skin instead of its smooth, glistening membrane-like appearance, had again acquired its natural, dartrous character, and the sensitiveness of the parts was also much lessened. As the patient, however, was still very uneasy I then determined to make an attempt to aspirate the tumor, as I now no longer feared any new effusion into the cavity.

Accordingly on my next visit (Wednesday) I first introduced a hypodermic needle by means of which I drew off a few drops of blood. I then inserted the smallest needle of the aspirator from above downwards into the tumor, preferring this direction to the insertion of the needle in its most dependent portion, as would otherwise be most natural, in order to avoid breaking the skin and leaving a chance for the entrance of septic fluids. By careful manipulation I thus gradually withdrew about an ounce of dark-colored blood, leaving but a small mass, evidently a blood-clot, about the size of a hickory nut, in the lower end of the labium. The tumor at once collapsed like a bladder and the patient stated that she was greatly relieved—both in body and mind. I immediately placed a piece of ice on the parts in order to secure contraction as rapidly as possible.

It was with great satisfaction that I found on the following day (Thursday) that no refilling of the tumor had taken place and that the patient was now entirely free from pain and mental anxiety.

At 11 p.m. of the same day—showing how nearly her calculations were correct—the patient experienced the first labor pains, and at 7:30 a.m. of the next day she was delivered of a large female child, the labor as well as the subsequent period of childbed being normal. She made a rapid recovery and in a few days no vestige of the above-mentioned trouble was to be seen."

Dr. Wenning added that the rarity of this affection led him to report this case to the Obstetrical Society. It was the first case that he met with and upon interrogation he found that some of his oldest and most experienced colleagues in this city had never seen a case of hematoma vulvæ, at least during pregnancy. To show the rarity of occurrence he would refer to the following table, the greater part of which he compiled from Spiegelberg's and Charpentier's recent works on Obstetrics:

Name of Observer.	*Cases of Thrombus Vulvæ.*	*Cases of Labor.*	*Years of Observation.*
Johnson and Sinclair	7	13,748	In 7 years.
Hecker	5	16,435	
Dubois	3	14,000	
Hugenberger	11	14,000	
Späth	4	6,000	
Other Vienna observers before Späth	10	33,241	
Spiegelberg	5	5,000	
Deneux	3		In 40 years' practice.
Hervez de Chegoin	1		20 "
Charpentier	2	18,000	2 last years.
Scanzoni	15		
McClintock	25		
Barker	22		
Gueniot, Perret, and Bouchard, each	2		
Winckel	1	1,600	

From the above table it would be seen that McClintock saw the largest number of cases of hematoma vulvæ in the practice of any single author.

Winckel estimated the proportion of hematoma to the total number of cases of labor collected by him as 1 : 1600, which is considered by Spiegelberg as too high.

The foregoing table, after omitting those cases where the number of labor cases are not given, fixes the average at about one case of hematoma to every two thousand cases of labor.

But rare as hematoma of the vulva is in the pregnant state, it occurs still less frequently before the inception of labor. Of 43 cases collected by Perret, he found only 2 that occurred before labor, 6 after the onset and 35 after its completion.

The most interesting feature in this affection is the cause. Aside of traumatism which may take place during pregnancy—and is then more apt to be followed by an effusion of blood into the cellular tissue on account of the greater vascularity of the parts—as well as in the non-pregnant state, there must be some predisposing cause by which the vessels are more easily ruptured. Most authors mention varicose veins as one the causes, although the majority of them agree that these enlarged vessels are only a secondary and not a primary factor in the production of this accident, while some, as Spiegelberg, regard their presence as only accidental. Barker even goes so far as to say that varicose veins predispose against hematoma, although he does not consider it worth while to give the reason. Of the 43 cases collected by Perret only two resulted from varicose veins. Winckel found varicose veins only six times in fifty cases, Scanzoni but once in fifteen, Outrepout none in four, Braun none in eleven and McClintock and Barker never saw an instance in their large number of cases of hematoma vulvæ. Wernich, who reported a very remarkable case before the Berlin Obstetrical Society a few years ago, considers the vascularity of the corpus cavernosum of the clitoris es-

pecially the predisposing cause of hemorrhage, and in proof of this mentions a case of accidental rupture of the parts from a fall which he saw in consultation with another physician, where the profuse hemorrhage that followed was shown to proceed from an injury to the corpus cavernosum. Even the unskilful use of the forceps, unfortunately so common a cause of injury to the soft parts, can in this instance be but rarely accused of having produced a hematoma. Winckel in fifty cases collected by him found that the forceps had been used only seven times. Lawson Tait, however, mentions a case where the forceps had been applied and slipped off *twenty* times, the parts were terribly bruised, a hematoma resulted and the unhappy patient finally died of septicemia.

Although hematoma vulva is still a dangerous complication, especially if the effusion be very large, the mortality is not now near so large as formerly. Thus Deneux, who wrote one of the earlist monographs on this subject, reports twenty-two deaths in sixty-two cases—a mortality of more than one-third, Blot records five deaths in nineteen observations, —nearly one-fourth,—Perret seventeen deaths in forty-three cases, Hugenberger four in eleven, whilst Scanzoni lost but one in fifteen, and Barker but two in thirteen hospital and none in nine private patients. All of these last two mentioned authors' fatal cases died from septicemia. Winckel mentions six deaths in fifty cases, a mortality of twelve per cent., which is accepted by Spiegelberg and others as the correct percentage at the present time. This decrease in the death rate is correctly attributed by Barker to the better treatment of these cases in later years. The earlier statistics date from the years 1830 to 1840 when it was common to incise these tumors at once to let out the effused blood, in consequence of which, no doubt, fatal hemorrhage must have often resulted. Thus the speaker for the sake of comparing the treatment of these cases in former years with that of the present time consulted the obstetrical work of Busch, who was a high authority in Germany about forty years ago, and found that this author urged immediate operation in all cases. Almost all authorities of the present time recommend the opposite course, namely, to apply cold compresses and to wait for the absorption of the clot, interfering only when the size of the swelling should obstruct the passage of the head during labor. Scanzoni and Barker, however, urge opening and turning out the clot. Their reason for so doing is to prevent the formation of an abscess and possibly subsequent septicemia; but even they recommend this procedure only when the first inflammatory symptoms have passed off and the swelling has ceased to fill with blood.

The speaker stated that a criticism might also be offered to his treatment of the case just reported, for the tumor was gradually decreasing in size and very likely would not have offered any obstruction to the passage of the head at the time of labor. His reasons for aspirating were the following: first, the hemorrhage into the cavity had ceased, so that no

refilling of the tumor was to be feared; secondly, the anxiety of the patient in looking forward to the impending labor was so great. He endeavored to reduce the swelling by means of the aspirator, because, should he not succeed, no harm would be done. He took the precaution of introducing the needle from above downward in order to avoid any possible entrance of septic fluid into this minute opening. Cold compresses had been tried before the operation but were not tolerated; when the blood was slowly withdrawn with the aspirator, however, the tumor collapsed like a bladder and the ice compresses were immediately applied and now well borne. The astringent property of cold undoubtedly caused a contraction of the vessels and prevented any further swelling.

This hematoma was of a venous character, a form that is in itself less dangerous than a thrombus following a rupture of an artery, which is more apt to be followed by subsequent hemorrhage and consequently contraindicates any operative interference.

DISCUSSION.

Dr. Gustav Zinke said he had had experience with but one case of hæmatoma vulvæ, occurring two months prior to delivery. This was of traumatic origin, the patient falling from a window astride the back of a chair, hæmatoma vulvæ resulting. Dr. Palmer was called in consultation and was afterwards in attendance at the delivery.

The tumor which was four inches in length by two inches in width at the time of the accident, was not interfered with. Cold compresses were applied; it did not increase in size and in a short time became a firm and hard tumor. At confinement it was about half its original size, still firm and hard. Aside from the use of the forceps it was a normal labor. There was a slight rupture of the perineum. After six months the tumor had disappeared entirely.

Dr. Reamy had seen in all four cases of hæmatoma vulvæ, two of which were in connection with pregnancy.

CASE I.—Occurred many years ago, three weeks prior to delivery—in this instance the hemorrhage was venous, very much like the case described by the essayist—in a patient who had borne a number of children, had varicose veins and bad circulation.

The hemorrhage was developed in drawing water from an old-fashioned well, the catch which held the lever slipping, and in endeavoring to grasp the latter she gave herself such a jerk as to throw her to the ground. She complained shortly after of great pain and a tumor was found in the right vulva. At that time he had just read statements of several authors concerning the danger from incising these tumors, and did not therefore practice it, but applied cold compresses and at the time of delivery the tumor had nearly subsided.

CASE II.—Occurred in a parturient on the second day after delivery,

involving the left vulva. The patient was a primipara and the labor had been protracted though not instrumental. The tumor encroached on the vagina so as to almost fill it. It was not opened, gradually subsided a slight suppuration occurring at the lower part later on. Recovery very slow but complete.

The other two cases were of traumatic origin.

CASE III.—The wife of a farmer fell from a ladder on to a picket fence tearing the perineum, which was united by sutures. Two hours after there was hemorrhage into the vulva. Neither in this case was the tumor opened but the patient was put to rest, cold applications applied, and morphia given. At one time he passed his finger into the rent in the perineum, (removing a stitch) thinking he might reach the seat of the hemorrhage and that it was blocked up by the torn edges of the perineum, but found it had been into the cellular tissue. This patient also recovered without any interference.

CASE IV.—Also of traumatic origin, occurred in a newly married woman, due to the great vascularity of the corpora cavernosa. The same treatment was applied in this case as in the others, also resulting in recovery.

Of these four cases only one had immediately anticipated labor, and this one had subsided so rapidly as to give him no concern since it offered no obstruction to delivery. He would consider himself justified, in any case where a thrombus of the vulva or vagina occurs prior to delivery, and is of sufficient size to obstruct delivery, in making an incision and empting its contents; of course delaying the operation until the tumor ceases to enlarge.

This rule was followed by Dr. Wenning before he aspirated. When no further enlargement takes place it is safe to assume that the pressure of the coagulated blood has obliterated the vessels so as to protect against hemorrhage. Unfortunately so much cannot be said for protection against septic absorption. For it takes more pressure to obstruct the lymphatics.

Where a tumor of this kind is opened at all by incision, it should be free, and bold, thorough; and compression with antiseptic dressings secured.

That fluid blood was obtained in Dr. Wenning's case and its removal not followed by refilling was a matter to the speaker of some surprise. But he would still consider the results obtained in the case an answer to all criticism as to the practice. He would therefore most heartily endorse Dr. Wenning's treatment. But in these remarks he did not wish to be understood as dissenting from the view that unless pressing reasons exist for incision it is best to omit it.

However, the same objections do not hold against aspiration as against incision. One of the conditions which the speaker would regard as de-

manding incision is where the growth of the tumor is so rapid and persistent as to threaten the patient's life from loss of blood. Here a free incision should be made and the hemorrhage controlled by compression within the wound.

As to causation he had nothing new or original to offer. Nothing could be clearer than that any causes which prevent the return of venous blood from this region may predispose to it. In pregnancy there are many elements favorable to this condition.

The pressure of the gravid uterus, organic changes in the heart, the changes in the constituents of the blood, the probable changes in the blood-vessels themselves, the emotional exaggerations which are laid upon the pregnant woman; all these may be mentioned as predisposing, at least rendering consummation of the accident easy. Enlargement of the liver, as in the case reported by Dr. Palmer, with its resulting obstruction to the portal circulation, acts upon the same principle.

Dr. Palmer said he distinctly remembered a case which fell under his observation some ten or twelve years ago. A middle aged woman, had a very large abdomen, the cause of which was not clearly defined, different opinions have been expressed by those who had examined her. While in very feeble health, and cachectic in appearance, she sat violently on the floor, striking her buttocks, having mistaken the position of a chair. She complained of severe pain in the region of the vagina, and an examination revealed the fact that it was much distended from behind by a large thrombus. Hemorrhage had taken place as a result of the fall into the connective tissue between the vagina and rectum. Instead of issuing from the bulb of the vestibule, as is usual in cases of vulvar thrombus, its source was the bulb of the vagina. No interference was resorted to. It increased in size, and in a few days burst through the vaginal wall. Immense number of clots were turned out. It filled up again and again, and in a few days more, the patient died of exhaustion. She would have died probably in a few weeks from the intra-abdominal disease. A post-mortem examination showed immense enlargement of both the liver and spleen—each weighing in the neigborhood of nine pounds. Here the primary trouble was the obstruction to the portal circulation with its direct influence on the pelvic, creating a varicose condition of the vaginal and rectal veins. The fall was the direct cause of the hemorrhage.

He had seen one other case of vulvular thrombus, besides the one seen with Dr. Zinke, reported by him. This was in pregnancy. Recovery took place without any interference.

But he could conceive of circumstances with hemorrhage (especially venous) occurring in the vulvar region—in delivery, or otherwise, from injury, where direct interference would be called for. The bloody effusion may be so great, and continuing, with distension of the tumor

and great pain, that it would be most prudent to incise the capsule of the thrombus, turn out the clots, stuff the bottom with lint wet in alum water, and apply a compress. The hemorrhage is then under direct control, the recovery will be more speedy. No doubt most of the cases recover, simply by rest, position, emptying the bladder and rectum, and applications of ice water; afterwards solutions of muriate of ammonia.

Dr. Trush had not met with a case of hæmatoma vulvæ in his practice unless the following case might have been one.

He was called to a woman in labor, but did not arrive until some hours after the birth of the child. Clots were escaping from the vagina, and upon examination a rent was discovered in the posterior vaginal wall, which could not be explained in any other way than that there had been a hæmatoma. The child was small and the labor had been very easy. Hot vaginal injections were given, some suppuration took place, but in the end she made a good recovery.

Dr. Wenning, in conclusion, said that he would like to have heard something said about the relation of varicose veins to hematoma. The statement of our authorities, who all mention varicose veins in the first place as a predisposing cause and yet are not inclined to regard this condition as an element in the formation of a thrombus, are conflicting. Of course where a trauma takes place when the varicose veins are already existing, a hematoma is easily accounted for, but in the speaker's case there was no history of an injury. It is true the sudden rupture might be attributed to straining while on the vessel, but during the simple process of micturition the strain could not be very great, especially as there had been no trouble before. In some cases we may perhaps suppose a diseased condition of the walls of a bloodvessel as the cause of rupture, especially in a part where vascularity is so great. Every one knows how intensely swollen and edematous these parts sometimes become, and the veins become so hard and thickened, that it seems almost a wonder that a rupture does not occur more frequently. The speaker once saw a case of rupture of a varicose vein in the leg during pregnancy. This patient, however, had a varicose ulcer which always became worse during this time. Here there was probably a diseased condition of the vein itself which could not resist the increased pressure of blood.

Uterine Cancer.

Dr. Thad. A. Reamy reported the following cases from his private hospital for women: (1)

Case 1. Mrs. Miller, Ohio, admitted April 13, 1883, æt. 47, married 31 years, 4 children, youngest 20 years; no miscarriages; labors normal.

First menstruated at the age of 15 years. Menstruated regularly until marriage, since when this function has not been normal; no serious ab-

1 Notes furnished by Dr. Wm. H. Kelly, Resident Physician.

normality, however, being present until within the last two years, since when severe hemorrhages have now and then occurred. There is usually a bloody discharge between the hemorrhages.

Has not considered herself well since her marriage, has been treated for leucorrhea and prolapsus. About a year ago there was an exacerbation of the symptoms and in addition a loss of strength and deterioration of general health. Was told by a competent physician that she had a cancer of the cervix. She then consulted an irregular, a so-called "cancer doctor," who made an operation on her, which, however, did her no good. In a few months the discharge became very offensive and she suffered with an almost unendurable pruritus of the vagina and rectum. Hemorrhage also present. This condition has continued now for about six months. Family history good.

Present appearance very cachectic; no appetite; bowels constipated; suffers so much from pain that she cannot sleep.

Vaginal Examination. Upper vagina filled with a rough irregular mass as large as a closed hand, bleeding to touch and emitting a very offensive odor. Mass very hard and induration extending up cervical tissue and shading off into vaginal vault. No marked involvement of vaginal tissue but the whole cervix was infiltrated.

Bimanual palpation of left ovarian region shows no marked enlargement, but patient complains of a severe boring pain in that region running into left hip. Right side normal.

Operation April 20th. Present: Drs. Phelps, of St. Mary's, O.; G. S. Mitchell, E. W. Mitchell, City. Patient placed in lithotomy position, etherized by Dr. Wm. Kelly, Resident Physician. Ecraseur chain pushed above the tumor so as to encircle its base slightly above the bottom of the cul-de-sac. This was accomplished by grasping the mass with a strong vulsella and dragging upon it. The chain was now tightened slowly, so as to completely compress the vessels, but not cutting through the mucous membrane. The entire mass was now cut off, with scissors, just below the chain. The only source of bleeding was from the circular arteries. From these, however, it was profuse so soon as the chain was removed. It was, however, soon checked by a stream of hot water. Of course, all cervical tissue, to a point slightly above the vaginal junction, was removed. And, so far as macroscopical appearances could show, all diseased tissue was included. Sound passed immediately into uterine cavity. Chromic acid freely applied and cotton (absorbent) packed over face of wound. Patient put to bed and kept easy with morphia hypodermically. In forty-eight hours cotton removed and carbolized warm water used three times daily as vaginal injections. In six days slough had separated, and there being some reddish unhealthy granulations these were touched with acid chromic. The face of wound is now as large as two silver dollars. For one month, every five

or six day, the wound was thus treated. The wound was now not larger than a silver quarter and no suspicious granulations. Wound looks somewhat indolent, but the tissues are soft and healthy.

During this time patient has improved in every way. Sleeps without anodynes, appetite good, and that intense pruritus has disappeared. She is out of bed and moving around the house.

No more acid chromic used. Wound treated every fourth day with arg. nitras (stick) and in about two weeks the granulations had entirely filled up the surface and in about one week longer cicatrization was complete and patient allowed to go home, apparently perfectly well.

CASE 2. Mrs. S., Iowa, admitted May 3d, 1883; aged 33; married twelve years; three children, youngest five years; no miscarriages. First menstruated at age of fourteen. Regular, until three years ago, since when intermenstrual periods have been only three weeks; flow scanty and somewhat painful. Family history good. Comparatively healthy until two and a half years ago, when leucorrhœa, accompanied by backache and bearing down pains, came on. These have continued till now. General health fair, except some nervous symptoms; especially well marked is the globus hystericus; suffers from migraine. Patient presents the appearance of robust health.

Vaginal Examination. Digital examination shows eversion of lips of os, hard and suspicious; induration, however, not well defined. Specular examination shows a typical bilateral laceration of cervix with eversion of os and ulceration of everted lips. Hardness now supposed to be due to cicatricial processes and the everted edges touched with solid arg. nit. and trachelorraphy to be made in ten days.

May 13th. Patient etherized and parts exposed. When tissues were grasped by a vulsellum the hardness and friability was suspicious, and and when cut with a knife the tissues creaked like cartilage. The suspicion that it was malignant was confirmed. (1) The hardness was found to extend up through the cervix to internal os and involved nearly all the cervical tissue. The mucous membrane, however, clear. The cervix was entirely removed by scissors in the following manner. Grasping the cervix with a vulsellum and making traction upon it a crescent incision was made encircling the anterior half of the cervical base, not, however, quite so high up as the anterior cervico-vaginal junction. Now, carrying the cervix forward by means of the vulsellum, a similar incision was made posteriorly. The junction of the anterior and posterior incision on each side was in the bottom of the lateral cul-de-sac. As the deeper cervical tissue was divided traction was continued, so that when the cervix was thus removed there was left an anterior and posterior flap. The stump was fish-tail in shape. The os internum was reached as the limit

1 Hardened sections of the tissue removed were carefully examined microscopically and the diagnosis confirmed.

of the section. The index finger could be carried through the os internum into the uterine cavity. Bleeding was profuse but was promptly arrested by the wire sutures, four on one side and three on the other, which were carried deeply through the anterior and posterior flaps, by means of a full curved needle, and by the twisting of which the flaps were firmly approximated. The first suture on each side was carried on a level with the bottom of the wound, and it was quite satisfactory to note with what ease this could be done with a full half-circle needle. And the promptness with which all hemorrhage ceased so soon as the sutures were tightened was gratifying indeed.

A sound was now passed into the uterine cavity to assure the operator that the opening had not been closed by the sutures. This was repeated every few days until after the sutures were removed, which was on the eighteenth day. Union was complete.

For several weeks after removal of the sutures suspicious granulations arose along the line of union, notably on the left side. They, however, ultimately entirely disappeared under occasional touching with solid argt. nit.

August 30th. An examination shows the parts perfectly healthy, not even the slightest cicatrix can be detected along the line of union. The patient menstruates naturally and is perfectly well. Of course there is no infra-vaginal cervix, but the os, perfectly normal in appearance, enters a prominence quite the shape of a cervix.

DISCUSSION.

Dr. Cleveland thought that if the cases reported should prove cures, Dr. Reamy should be congratulated upon his very fortunate results.

There is a general feeling in the profession that when cancer of the uterus is once developed that it is necessarily fatal. This is unquestionably an error. Malignant growths when confined to the cervix are frequently cured by operative procedure. He operated on a case of unquestioned malignant disease of the cervix some seven years ago, using chromic acid. There was no return of the disease up to the time of the patient's death, which occurred last summer from acute dysentery.

Dr. Palmer remarked that Dr. Reamy was certainly very fortunate in getting hold of two cases of the kind reported, where the cancerous disease was exclusively confined to the uterine cervix. It is a rare circumstance to meet with such cases; and this is one of the principle reasons why good results are not oftener obtained by operative interference. The Doctor is to be congratulated on the present good results. It is to be hoped they will prove permanent. Time can only decide that. Recognizing that cancer, at least in most instances, is a local disease, Dr. Palmer expressed a thorough belief in its curability. If the disease is attacked early enough, before surrounding tissues have become infiltrated, and thoroughly removed, a cure is promised. It is our misfortune not to obtain cases

at this stage. A vast majority of cases of uterine cancer are hopelessly incurable when detected. The patients have permitted the disease to go on, delayed seeking medical advice—until it is too late. This is true with reference to these parts (uterus etc.), in particular, because hidden from view, and because of the inherent dislike of women to an examination. Delay here is pre-eminently dangerous. There are conditions in and around the uterine cervix which render cancer a local disease but for a short time. The cervix, and especially the para-metrium, are very rich in blood-vessels and lymphatics. The soil is most fertile for the growth of the cancerous plant. Laceration of the cervix is a cause of cancer. The mucous inflammation, the granular degeneration, the cervical eversion, etc., *continuing* for a long time, present a condition, in the degenerate state of the tissue of advancing years, favorable to cancerous cell growth. Some of these cases of decided laceration, with granular degeneration, great eversion, and copious discharge, simulate cancerous disease. It is a question whether the microscope can *always* be relied upon in determining *which* is, and *which is not*, *cancerous*. There is a time and stage of either—and one, undoubtedly, does, at times, pass into the other. Several instances have come under the speakers observation, looking so much like cancer, that he was disposed to regard them at first as such, till local treatment, through great improvement, put this question of diagnosis at rest.

Connected with this subject of cancer of the cervix, comes the question of extirpation of the whole uterus. Is it a justifiable operation?

At the last meeting of the American Gynecological Society in Philadelphia, Dr. Palmer said he emphatically endorsed, for the most part, the position taken by Dr. Jackson, of Chicago, that it was not a justifiable operation. Dr. Jackson's paper was a very able one, calculated to do much good in the profession at this time, while this question was *sub judice.*

Dr. Palmer said so far he had declined to make this operation, for as yet no case justifying it had come under his observation. He thought that in reference to this operation all cases of uterine cancer may be divided into two classes. *First: Those in which it is clearly unjustifiable. Second: Those in which it may be justifiable.*

Under the first head, may be included every case of primary cancer of the cervix—a vast majority of all cases of the disease. If any operation at all is required in this class, it is not total extirpation. First: Because excision of the cervix, as referred to in the report this evening, and as recommended several years since by *Sims*, and as since practiced by *Baker*, of *Boston*, is equally effectual, if the disease can, in any way, be removed. If it has infiltrated the para-metrium, total extirpation can remove as much, no more. Confined as the disease is to cervix, excision of that, attacks the whole territory of infiltration; what, then, is the use

of extirpation of the uterine body? *Second:* Excision of the cervix is infinitely a less dangerous operation than total extirpation, performed either after the method of *Freund* or *Schroeder*. The element of safety then, of cervical excision, has much to recommend it.

Under the second heading come cases of cancer of the uterine body: the hard and soft sarcoma—rare diseases as compared with the different varieties of malignant disease of the cervix. In some of these cases, Dr. Dr. Palmer said he could admit that total extirpation was justifiable. On just the same ground that the disease is possibly curable in the cervix, if wholly removed, why not if strictly confined to the uterine body? At this point arises the difficulty, both as to *diagnosis*, and the *extent of the* disease. Cancer of the uterine body, a rare disease, is less likely to be detected, either as to its nature or extent, than when limited to the cervix. If its nature is absolutely revealed, who is, or can be, positively certain that the lymphatics and connective tissue of the upper pelvic viscera do not contain more or less cancer cells and nodules? The uterus may be normally mobile; touch per vaginam and per rectum, and the most thorough bi-manual exploration may fail to detect a single evidence of a positive extension. *If the operation is undertaken, it should be with every outward assurance that the disease is confined to the uterus; but it must, necessarily, always be undertaken with a doubt as to whether it actually is.* Extirpation of the uterus must, then, be confined to a very narrow field—a very limited few cases, indeed.

Now this operation is not to be abandoned because it is difficult of performance; nor, because it has been followed in its immediate results by a heavy mortality. Cancer, left to itself, is sure to kill; hence a dangerous operation is warranted. A desperate disease justifies a desperate remedy, if there is no safer one. Furthermore, time and experience will greatly simplify and improve the technique of the operation, and with it, gradually diminish the mortality. See what it has done already. Experience shows that *Freund's* operation ought to be almost abandoned—because more difficult, attended with greater shock, and the fearful mortality of 70 per cent. The vaginal method of *Schroeder*, *Martin*, and *Czerney* is much to be preferred, except when the uterus cannot be removed in this way; for statistics show it has been attended with a mortality of only about 30 per cent.

But what are the statistics in reference to *ultimate* results of this operation? *How many*, of those who have survived the immediate effects of operation itself, *live*, and *do not have a return of the cancerous disease?* It is in the answer to this question that we are to obtain our most reliable and best information, as to whether total extirpation is a justifiable operation. Statistics on this point show that 50 to 75 per cent. die from a recurrence of the disease within a few months; and nearly all as soon as if no operation had been made. One of Freund's cases, it is reported,

was free from a recurrence for four years and ten months: and that in nineteen cases operated on by the vaginal method, there was no recurrence for periods varying from three to twenty-four months. Death ensued, on an average, in quite a number of cases, in about fourteen months.

Judging by these figures, (and they come from sources which favor the operation), the ultimate results are not very brilliant, and only go to confirm the previous statement of the extremely limited field of utility of the operation of total extirpation of the uterus for cancer.

Dr. Reamy said he had reported the cases to-night, not for the purpose of going at any length into the discussion of the subject of partial or total extirpation of the uterus, but he thought even the very brief report which he had made would have special interest to members of the Society, in consequence of the fact that this subject is now to an unusual degree attracting the attention of the profession both here and abroad.

Most able addresses on this subject had been delivered by Dr. J. Wallace, of the Royal Infirmary, Professor of Obstetrics in University College of Liverpool; Prof. Carl. Schrœder, of Berlin, and Dr. A. Wynn Williams, of the Samaritan Free Hospital.

Members who desired to read these addresses would find them in the *British Medical Journal*, of September 15th. A very able paper upon this subject was also read at the last meeting of the American Gynecological Society, held in Philadelphia, by Prof. Reeves Jackson, of Chicago. This paper was exhaustive. The conclusions arrived at by Dr. Jackson, apparently thoroughly justified by the facts and statistics presented in his paper, are against total extirpation of the uterus except in very rare cases.

Dr. Reamy had refused in no less than twelve instances, during the past two years, to make the operation of total extirpation of the uterus for cancer; having been urged to do so. His refusal was not on the ground of the difficulties in making the operation. Any one having a thorough knowledge of the anatomy of the uterus and accustomed to surgical work may perform the operation, either by the vagina or by abdominal section. But the results of the operation, even in the hands of those most accustomed to it, and the strongest advocates for it, are not such as to justify it in the judgment of the speaker, except in rare instances.

He had read the reports of all the published cases accessible to him, and had arrived at the above conclusions prior to hearing the paper of Dr. Jackson, but he would confess that this paper had more strongly confirmed him in the belief that the operation is rarely justifiable. He would not be understood as condemning extirpation of the body of the uterus by abdominal section in a case where the disease could be correctly diagnosed as confined to the body, the cervix, super-vaginal and

infra-vaginal remaining healthy. But such cases are extremely rare and quite difficult, before the operation, of diagnosis. He certainly would not condemn extirpation of the cervix in cases where the corpus is unaffected, for he believed that in such cases, if the operation be early and thoroughly done, there is much hope. The two cases which he had reported to-night testify in this direction, and he could add to them quite a number of other cases, of similar character with similar results, following operations, which had occurred in his practice in former years. He remembered especially two cases amongst those which had been reported elsewhere, the diagnosis being unequivocal, in which he had removed the cervix, there being no recurrence of the disease. One of the patients dying seven years after the operation of typhoid fever. The other is still in good health nine years after the operation. He had removed the entire cervix uteri four years ago from a Mrs. Dixon, who resides in Racine, O., and up to the present time there has been no return of the disease. The patient, on the contrary, is enjoying perfect health. At the time of operation the cachexia was well marked. And so thoroughly was the entire cervix involved that he had to dissect in front and posteriorly above the cervico-vaginal junction, as in one of the cases reported to-night, in order to remove all the diseased tissue. Indeed, posteriorly, he had really uncovered the anterior peritoneal wall of Douglas' pouch. The variety of cancer in this case was the so-called cauliflower.

In former years he had often been misled in his clinical study of cases by so-called constitutional cachexia. Without special regard to the local manifestation of the disease further than its diagnosis as malignant, he had formerly considered a marked cachexia as conclusive of consitutional infection to an extent that warranted an unfavorable prognosis, no matter how thoroughly the local disease might be removed by operation.

On the other hand, in cases where there was no apparent cachexia, he had accepted this fact as presumptive of but little constitutional involvement and therefore in favor of a good prognosis. More extended observation in modern years, however, has convinced him that no reliance whatever can be placed upon the so-called cachexia. He had seen several cases where the disease had involved the entire cervix and infiltrated the upper vaginal sub-mucous tissue, with extensive involvement of the pelvic lymphatics in all directions where they could be reached for examination; and yet the complexion and nutrition of the patient indicated perfect health, no perceptible cachexia whatever being present. He recalled two such cases occurring within the past year, wherein death followed within two to four months of the time of examination. Again, as in the first of the two cases reported to-night, he had removed the local disease in a subject where the cachexia was well marked and had

obtained the most satisfactory results. He must conclude therefore that this whole question of cachexia is still involved in obscurity.

The speaker would say that he now placed a lower estimate upon the beneficial results of operative procedures simply with a view to palliation than he had formerly done. Certainly in bad cases, where the hemorrhage and offensive discharges exhaust and annoy the patient, and where from pressure by necrosed tissue there is intolerable pain, he would advocate scooping out and trimming away and cauterizing. No one can doubt the propriety of such treatment who has witnessed the great relief so afforded in such cases. Every one knows how markedly the general condition will sometimes improve after the removal of most of the diseased mass. Nevertheless, it is now his opinion that even in such cases this improvement is frequently very deceptive. The breakdown and fatal termination of the case possibly being precipitated all the more rapidly by reason of surgical interference. These remarks might surprise some of his friends. He was aware that during the past twelve or fourteen years he had operated upon hundreds of cases and many of them in the public amphitheatre of a hospital. Both in the clinical lecture room and in societies he had strongly advocated the practice. He would not now be understood as condemning it, but he had become far more conservative and felt himself justified in being more circumspect in the selection of cases, even for the employment of surgical palliative treatment. He employs caustics in the destruction of tissue in such cases far more extensively than formerly, and knows of none which acts as satisfactorily as chromic acid. This agent dissolves the tissue to which it is applied almost as readily as heat melts snow, at the same time it does not penetrate so deeply and is therefore far more manageable than most other caustics in use for such cases. He prefers it very much to the actual cautery. He had not seen the disease progress more rapidly apparently as in cases where cutting had been employed.

The Society would pardon him for what might seem almost a repetition, viz.: He would unhesitatingly in every case of the so-called cauliflower excrescence of the cervix, operate by the ecraseur or the scissors, as in the cases reported to-night, or both, provided a line of healthy tissue could be reached, applying the chromic acid if need be to the stump, or omitting it as might seem proper. In this variety of the disease the pelvic cellular tissue and the lymphatic glands are by no means so likely to be involved He had frequently seen in this variety the entire infra-vaginal portion of the cervix involved, but not a vestige of induration upon or infiltration beneath the vaginal mucous membrane. These are the cases for operation. Thoroughly made in such cases there is much hope that the disease will not return. But should it recur many years may first intervene.

On the other hand when epithelioma has attacked the cervix even

though this portion of the uterus may not apparently be extensively involved the uterus remaining perfectly mobile, if there should be infiltration of the submucous glands in the upper portion of the vagina, no matter how thoroughly the cervix may be removed, or by what methods, recovery will not occur; the disease will progress probably the more rapidly for the interference.

On the qnestion of diagnosis, the speaker had found no difficulty, except in cases where laceration of the cervix had been followed by induration with excoriation, and in rare cases ulceration, and further on perhaps malignancy.

Some years ago a case of this kind was sent to him for examination by a distinguished surgeon of this city. The patient was the wife of a prominent physician in another city. She had come to the surgeon for examination. The surgeon believed her disease to be malignant, and sending her to the speaker for confirmation or contradiction of that belief, he had made an examination which led him to concur in the opinion that the disease was probably malignant and he so expressed himself in a note to the surgeon, advising immediate operation for removal of the neoplasm. This patient soon after went East and was operated upon for the lacerated cervix by a distinguished gynecologist, a perfect cure resulting. Both the speaker and the surgeon had recognized the laceration but they probably mistook the deep cicatricial induration for malignancy. Nevertheless, since such cicatricial tissue is now known to be quite prone to become cancerous, they may not have been so far wrong after all. The removal of the cicatricial tissue in the operation for trachelorrhaphy may have saved the patient, probably did from that which would have been cancer. Indeed, he has no assurance that it was not then already malignant; still, at the time when this case occurred, the subject was not so well worked up as now and mistakes were far more common. He is fully convinced that trachelorrhaphy saves many women who would become victims of cancer. He had seen many cases in point.

Per Contra.—A woman had been sent to the speaker by a gentleman of national reputation in an Eastern city, who informed him in a note that the patient had suffered of a fibrous tumor of the uterine cervix, which had been removed during her temporary sojourn in the East, and which would probably give no further trouble, but as a matter of security she was referred to the speaker to look after. He, the speaker, examined and found the entire infra-vaginal portion of the cervix indurated with cancerous infiltration, and at the point of the recent operation rapid breaking down. The speaker wrote his Eastern friend the situation, receiving the reply that there was "not even a suspicion of cancer in the case!" "It was fibrous and nothing else. Not only had a careful clinical diagnosis been made in the East, but the specimen removed had

been examined by the most competent microscopists. There could therefore be no mistake."

The speaker removed by galvano-cautery wire all the vaginal portion of the cervix and scooped out with spoon saw above, but all to no effect. The patient passed out of his hands but only to die, as he had assured her friends she must, nearly a year later. This patient was sent to the speaker within two or three weeks after the operation made in the East, and he was severely criticised by her friends for pronouncing the case one of cancer.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, November 1st, 1883.

The President, R. A. CLEEMANN, M.D., in the Chair.

Dr. B. F. Baer related the following cases, the clinical histories of which present some points which he thinks are instructive and worthy of discussion. They are somewhat unusual in character, and remarkable that they all occurred within a period of thirteen days.

FORCEPS LABOR, FIFTH POSITION.

On October 17th, I was requested by Dr. ——— to visit his patient, Mrs. H., who had been in labor thirty-six hours, prepared to perform craniotomy. She was a primipara, 43 years of age.

I found the patient nervous and exhaused, the soft parts dry and rigid, the os partially dilated and the membranes ruptured many hours. The head, a large one, was in the cavity of the pelvis, and, whilst not impacted, it was nearly so. The larger portion of the head was posterior and to the left, the smaller portion, anterior and to the right. The fœtal heart-sounds were heard in the left lumbar region and nowhere else. I therefore diagnosticated a left occipito-posterior, or fifth position of Baudelocque.

I placed a vectis, and endeavored to assist rotation forwards, but failed to make any impression. I next adjusted, with some difficulty, Simpson's forceps, and by traction during uterine action, with gentle efforts at rotation, allowing the forceps to turn as the occiput rotated anteriorly, that process was finally accomplished in about two hours of hard work. I now removed the blades, and after finding that the head could not be delivered with it, I readjusted the instrument and assisted in extension of the head, delivering a living a child said to have weighed twelve pounds. There was no laceration of the perineum. Both mother and child have done well. The case is interesting because of the age of the primiparous patient, and in the position of the occiput, which is rare.

ARM PRESENTATION; PODALIC VERSION.

On October 23d, Dr. ——— requested me to see a patient with him,

a girl sixteen years of age—a primipara at full term—in labor about twenty-four hours, and trunk presenting.

In general appearance she resembled more a child of twelve than a girl of sixteen. The external genitals and vagina were small and undeveloped. The abdomen was greatly distended, globular, and fluctuating. Palpitation was of only negative diagnostic value, probably on account of the large quantity of amniotic fluid. But I thought I detected the head in one iliac fossa, and the breach in the other. Auscultation revealed the fœtal heart-sounds, feebly heard in the right iliac region. The upper portion of the vagina was distened by a large, protruding, "bag-of-waters," and the os uteri was fully dilated. I could only slightly touch the presenting part, which was entirely above the superior strait. I detected what I thought to be a limb, and from what I had learned previously by inspection, palpation and auscultation of the abdomen, I believed it to be an arm. I then dilated the orifice of the vagina preparatory to passing my hand, should that be found necessary, after rupture of the membranes, which I now did, and found a shoulder presenting and an arm on the verge of passing the os. This I arrested, and made version by the feet. I preferred this to vesion by the vertex, because I deemed it easier and less dangerous to both mother and child to effect delivery in that manner, than to apply the forceps in this special case. The child was alive, but feeble. The body passed through the narrow vagina very slowly, and only after pressure on the fundus of the uterus, until the head reached the floor of the pelvis. Here, by assistance, the occiput rotated forwards and the head was arrested. Flexion of the head could not be made to occur by supra-pubic pressure, and by pressure upon the nape of the neck, whilst a finger or two acted upon the anterior surface of the head through the rectum. I then quickly adjusted the forceps, and carrying the handles forward with the body of the fœtus, made flexion and deliverd a living child. There was not the slightest laceration of the perineum.

The uterus did not contract well; and although ergot was administered, and time given for the organ to recover its tonicity (thorough kneading being used meanwhile), when the placenta was expelled a smart post-partum hemorhage followed. This was easily controlled by the application of pure vinegar to the cavity of the uterus, injected by means of the long-nozzled uterine syringe, which holds about half an ounce. I prefer this method of introducing the vinegar to any other, for the reason that it is more easily and thoroughly applied. I carry the nozzle, guided by the index finger, as in the introduction of the sound, into the uterine cavity, and project the vinegar, without force, over the surface. This can be repeated if necessary, which is seldom. Too much praise cannot be accorded Prof. Penrose for his earnest advocacy of the use of vinegar in the treatment of post-partum hemorrhage, the result of uterine inertia.

In my experience, it has never failed to secure firm and continous contraction, when properly applied. It is simple, antiseptic, and harmless.

ARM PRESENTATION; PODALIC VERSION.

October 29th Dr. ——— sent for me, stating that he had a case of shoulder presentation, that the membranes were ruptured, and the os only partially dilated. He had attempted to make version by the feet, and had brought down an arm in mistake for a foot. I found a primipara, æt. 22 years, illegitimately pregnant, at full term, feverish and excited. A large, fat right arm occupied the vagina, and the shoulder was jammed into and projecting through the os, which was firmly contracted around it. It was a dorso-posterior position, and the head was in the right iliac fossa. All the liquor amnii had been drained away, and the uterus was closed tightly around the child, which was apparently dead.

We administered ether, and I at once began an effort to bring down a foot, deciding that version by the vertex here could not be made, because the arm could not be returned to the uterine cavity, and, even, if the arm had not been down, I feel sure that the bi-polar force would not have been great enough to have brought that head to the superior strait. But to get through the narrow vagina and rigid os, which were filled already by the arm and shoulder, was one problem, and another, apparently greater one, was the turning of the large child in a contracted uterus. An attempt was, however, not only justifiable, but obligatory, for the sake of the child, of whose death we were not sure. Then embryotomy, in a case of this character, would, I believe, have been attended with greater danger to the mother than version. I gradually inserted my hand and carried it into the uterine cavity, and with it I tried again to replace the arm, but failed. My hand was now so benumbed that almost all sensibility was lost. However, I finally reached the feet, selected the uppermost or left one, and began my efforts at version, assisting all my internal manipulations, of course, by placing the external hand on the abdomen, and acting with it on the opposite pole of the child. When I made traction on the leg, the arm advanced further into the vagina, and it now seemed that I should certainly be compelled to give it up, the difficulties appeared so great. But patience and perseverance are cardinal virtues here, and by exercising them to my utmost capacity, I succeeded in getting the foot and leg into the vagina, where I secured them with a fillet. I now gave this to Dr. —— – and whilst he made traction upon it, I pushed upon the shoulder, and succeeded finally in revolving the child on its long axis, causing the arm to ascend and the leg to occupy its place in the vagina. The remainder of the delivery was that of a difficult breech case, where traction of the child and pressure upon fundus of the uterus are imperative. The child was dead. The mother reacted well, and has not presented an untoward symptom. There was

slight laceration in the sulci on either side of the vagina, not through the cutaneous surface, and not enough to require suturing.

BREECH PRESENTATION.

Twenty-four hours later, on October 30th, my friend Dr. Wm. L. Taylor requested me to see with him Mrs. X., a primipara, thirty-five years of age, who had been in labor twenty-four hours, the breech presenting in the left sacro-posterior position. The membranes had ruptured twelve hours previously, the os was rigid, and only slightly dilated, and the breech was impacted in the superior strait, which seemed to be narrow. The patient was short of stature, fat, and had a small vagina. It was thought that the child was dead, but of this we were not sure.

Was there any use in waiting longer for nature to effect delivery? We decided that there was not, and, I believe, correctly. An attempt at traction was made by acting on the thigh, but it was futile. I passed my hand with great difficulty into the cavity of the uterus, which closely surrounded the child, and endeavored to reach a foot, but found that the legs were extended; and it was only after I had advanced my hand absolutely to the fundus of the uterus that I secured the desired member. The uterine cavity was now so rigid and full that it appeared impossible to flex the leg, and extend the thigh. But here perseverance again succeeded, and the leg was brought into the vagina. Delivery was finally consummated by the greatest effort. The child was dead, and from apearances had been so for some hours, Dr. Taylor had suspected. The mother recovered, as after an ordinary labor.

PUERPERAL CONVULSIONS.

A few days before, October 21, there entered my service at the Maternity Hospital a girl, eighteen years of age, illegitimately pregnant, and near term. She presented a depressed appearance, and was pale and puffy from œdema. Her urine was examined at once, and found to contain a large quantity of albumen and some casts. Her labia minoræ were so œdematous that she walked with difficulty.

She was placed upon a treatment consisting of Basham's mixture, digitalis, laxatives, and warm baths, with good food. On the 20th, the nymphæ were so greatly distended that I feared obstruction to delivery, which was about to take place; I therefore made about a dozen small punctures over their surfaces. This was followed by a very free discharge of serum, so that in the evening the labia were reduced more than one-half. During the night, labor occurred, and she was delivered naturally at seven a.m. on the 21st, having been attended by my assistant, Dr. J. P. Pyle. There were no symptoms during the labor nor immediately after it to attract attention, but before leaving her, he administered thirty grains of the bromide of potassium as a safeguard.

At 9 o'clock he was hurriedly called, and found her just recovering from a convulsion. He at once sent for me, and began the administra-

tion of chloroform. But before I reached her, at 10 o'clock, she had had two more seizures, and just as I entered the room she went into another, which was one of the most terriffic convulsions I have ever witnessed. I immediately opened a vein and allowed about sixteen ounces of blood to flow. I will confess that I did not want to take blood from this patient, because she was in such an apparently low condition. The bleeding did not seem to have the slightest effect, for very soon after it she had another convulsion fully as severe as the one preceding. Since the first attack there had been given, per rectum, twenty grains of the hydrate of chloral and forty grains of the bromide of potassium, and, per os, one-fourth of a grain of elaterium. But the convulsions continued to recur, unless the patient was kept constantly under chloroform, and coma was deepening with each attack. I now injected, hypodermatically, three-fourths of a grain of the sulphate of morphia. This was 11.30 a. m. She did not have another convulsion, although no more chloroform was administered until 2 p. m. At this time she had a slight one, and at 2.30 another much more severe, when I repeated the dose of three-fourths of a grain of morphia. After this she had no more convulsions. The dose of elaterium was now repeated, and the kidneys stimulated by large doses of saline diuretics, administered by the rectum. The bowels moved freely and repeatedly soon after the last dose of elaterium was given, and the kidneys responded promptly; but the urine became nearly solid, when the test for albumen was applied, and casts were so numerous, and of such a character, that an unfavorable prognosis was pronounced by the competent microscopist who made the examination. The patient, however, came gradually out of the profound coma, but did not recover consciousness until nearly three days had elapsed, becoming at times wildly delirious and maniacal. As soon as she could swallow, I resumed the administration of Basham's mixture and digitalis, and on the next day added quinine and ergot, the latter especially to restore tone to the capillaries, and thus assist in improving the condition of the brain. Milk and beef tea were given largely. The patient will leave the hospital to-morrow, although her urine still contains albumen in considerable quantity.

If uræmia is ever the cause of eclampsia (which is not settled), this case presented the kidney state which is usually found in cases said to be of that origin.

Since it is apropos, I will relate a case which was probably not of uræmic origin, because the urine did not indicate the slightest disease of the kidneys.

Puerperal Convulsions.

My friend, Dr. J. B. Deaver, asked me to assist him in the delivery and treatment of a case of convulsions. The patient was eighteen years of age—a primipara, and unmarried. The occiput was posterior and in

the hollow of the sacrum. The first convulsion occurred after the head had passed the superior strait, and it was a very severe one. Dr. Deaver immediately bled, and very freely. Another convulsion occurred soon after the bleeding, although chloroform was administered and chloral given by the mouth. When I reached her, she had had three attacks, and was profoundly under the influence of the anæsthetic, and, of course, could not convulse in that state. I adjusted the forceps and delivered, with the occiput posterior, being unable to rotate it anteriorly. The anæsthetic was now removed, and not long after another violent convulsion occurred. I now injected two-thirds of a grain of morphia under the skin. She did not have another seizure, and made an uninterrupted recovery.

As stated above, there was not the slightest evidence of disease of the kidneys, either before or after labor. The cause here was reflex—the patient being predisposed by a depressed mental condition, etc.

The first indication to be met in the treatment of puerperal eclampsia should be to control the convulsions. I do not think it will be gainsaid that the prognosis becomes less favorable with each recurrence. I believe morphia, administered hypodermatically in a large dose, and repeated, if necessary, is one of the most efficient, if not the most efficient, means which we possess for that purpose. In the next case which I am called to treat I shall give one grain. I will bleed, if I think that it is indicated, and shall use chloroform; but I will certainly give the morphia. I will then attend to elimination through the bowels, kidneys, and skin. Dr. Clark, of Oswego, N. Y., first brought the morphia treatment before the profession, in a fearless and excellent paper, published in the *American Journal of Obstetrics* for January, 1880, which is worthy of study.

DISCUSSION.

Dr. Elliott Richardson thinks the extent of dilatation of the cervix a very important point in considering the advisability of version in shoulder presentations. When the fetus is in a transverse position it cannot descend, and as the cervix dilates it slips upward on the neck and chest of the child and thus puts the vagina in a condition of longitudinal tension and consequently of narrowing. Any sudden or extreme attempt at dilatation of the vagina, when in this condition, involves a great risk of laceration. In Dr. Baer's case the narrowness of the os uteri was a favorable circumstance for podalic version.

There is a wide difference in the treatment of puerperal convulsions, between this country and Germany. Carl Braun strongly discountenances bleeding and recommends chloroform with the administration of benzoic and citric acids to assist the action of the kidneys. He considers that the prime object is to put the body at rest.

Dr. W. T. Taylor thought that in case 2 if the method of Dr. Wright, of Cincinnati, for the correction of the shoulder presentation by con-

verting it into a vertex had been tried, the difficulties and dangers of a version by the feet might have been avoided.

He does not think bleeding should ever be omitted in the treatment of puerperal convulsions in plethoric patients. Bleed freely and give chloral in large doses by the rectum. He thinks the use of opium should be preceded by bleeding.

Dr. Alfred Whelen has tried ¼ grain nitrate of pilocarpine hypodermatically after bleeding, the result being successful. The use of the pilocarpine did not seem to be followed by serous effusion. In one case in which the no treatment of any kind had been used an autopsy showed all the serous cavities filled with effusion. He thought the arterial tension consequent on the convulsion was the cause of the exudation.

Dr. R. A. Cleemann had tried all plans and none of them were certainly successful, every method would fail at times and any method will be followed by recovery. He thinks bleeding should be tried in every case to remove the vascular tension, which is the great source of danger.

Dr. B. Trautmann had under his care a primipara, plethoric, who was suffering from puerperal convulsions, she was bled, a large dose of calomel was given, chloral was administered and pilocarpine was injected, but all without effect, the patient dies. In another case the urine contained 50 per cent. of albumen with casts and no convulsions occurred. What is the relation between albuminuria and convulsions? Is the origin of the convulsion in the nervous system, and the albuminuria a result?

Dr. H. F. Beates. The presence of urea in the blood being generally considered a prime factor, most of the forms of treatment have reference to its elimination. Bleeding should be very free to act in that manner, and if it is prompt and free it will be followed by improvement; pilocarpine acts as an eliminator of urea by the skin thus relieving the kidneys and the system. He had treated two cases by this method and both had recovered.

Dr. Philip M. Schieat had recently under his care a primipara, aged twenty-five years; she had had convulsions for four hours. Chloral and bromide of potassium had been given freely, but with no effect, a hypodermatic injection of ¾ grain of morphia sulphate was followed by quick relief; she was very plethoric, but there was no need for bleeding after the use of the morphia.

Dr. Baer in case 2 had considered version by the vertex, but thought that he could deliver more quickly and with less danger to both child and mother by means of podalic version. He considered elimination a false principle in the treatment of puerperal convulsions. First stop the convulsions, eliminate afterwards if there be any necessity for it. How much elimination can be affected by drawing twenty or even forty ounces

of blood? The majority of these patients need all of the blood they have; they have none to spare. There is a neurasthenia at the bottom of these attacks. The patients are generally nervous and depressed from circumstances connected with their physical and social condition. Dr. Penrose, at his lectures at the University, taught bleed—bleed—every case that was bled sufficiently got well, every case that was not bled died. Dr. Carson's lecture followed immediately after that of Dr. Penrose, and he was as bitterly opposed to bleeding as Dr. Penrose was enthusiastic in its advocacy. He has been afraid of pilocarpine because its action, once established, cannot be controlled; he thinks, however, the effusions observed have been caused by the convulsions and not by the remedy. Morphia, used hypodermatically, is the remedy upon which he puts dependance, it will control the convulsion. Any medicine administered by the mouth or rectum must be of slow and uncertain action, because of the slowness of absorption from the alimentary tract.

Dr. Beates reported a case of

DIPHTHERITIC PARALYSIS

in a child of eight months. The muscles of the neck were affected and resulted in extreme flexibility of the neck, the head rolling all about. Death resulted apparently from paralysis of the phrenic nerve.

Stated Meeting, December 6th, 1883.

The President, R. A. CLEEMANN, in the Chair.

CYSTS OF THE PAROVARIUM.

Dr. W. Goodell exhibited two cysts of the parovarium and remarked: Both patients got well; he, indeed, had never lost a patient from whom he had removed a parovarian cyst. In both cases a correct diagnosis was made previous to the operation. One interesting diagnostic point was the complete absence of the *facies ovarina*. The color in the cheeks was good and the countenance was free from the anxious expression present in cases of ovarian tumor. One tumor had existed for ten years, the other for one. Another important point in the differential diagnosis is not only the flaccidity of the tumor but its variable degree of flaccidity. Upon inspection it is seen to reach to the sternum and seems to occupy a large portion of the abdominal cavity, but when the hands are placed upon its sternal edge it can be compressed to the level of the umbilicus. An ovarian cyst on the contrary is hard and uncompressible. Exceptions to this rule are vary rare, that is, either a tense parovarian cyst or a flaccid ovarian one. A third important distinguishing point is the long time—ten years in one case—which the tumor existed, and, further without marked deterioration of health. After being tapped these tumors usually refill, but occasionally they do not, and a cure is thus brought about. The fluid withdrawn has been in every case limpid and generally color-

less, but it has sometimes had in his experience an emerald tint. These tumors are generally free from serious adhesions, but if in an operation for the removal of one, adhesions should exist where for any reason their forcible separation would be unadvisable, or the cyst were intra-ligamentous he would not hesitate to leave the adherent portion of the cyst-wall or the whole cyst itself, after making a big hole in it, as the fluid it secretes is bland and unirritating to the peritoneum.

Any one examining one of these cysts for the first time would consider it to be of ovarian origin; for it is only by patient search that the ovary can be found spread out over the cyst-wall. The microscope will decide with certainty in any otherwise doubtful case. The tumor is covered with a beautiful net-work of veins.

When a cyst of the parovarium exists on one side, the ovary on the opposite side is usually found to be diseased and should be removed. In these cases the remaining ovary was seen to be enlarged, and the site of a small ruptured cyst was pointed out. The fallopian tube was also enlarged, and the terminal vesicle of the fallopian tube or the hydatid of Morgagni was enlarged and cystic. This hydatid sometimes attains the size of an orange and often ruptures spontaneously without any bad effects. A few years ago one of these small cysts ruptured while he was making an examination of the patient to ascertain its character.

Dr. Goodell exhibited a

CANCEROUS WOMB REMOVED PER VAGINAM.

In view of the very fatal statistics of the operation for the removal of the womb for the radical cure of uterine cancer, he had been unwilling to perform it. In most of the cases where the disease had been seen early enough by him to give a chance of success, the patient had been unwilling to take the risk. On one occasion when every preparation had been made to operate, the patient had a convulsion, and an examination of the urine showed a high proportion of albumen, in consequence of which he refused to operate. About a month ago Dr. Chas. W. Dulles called him in consultation to see a patient in whom the carcinomatous condition was limited to the anterior lip. The womb was movable. The case was put frankly before the patient and all its dangers pointed out. The choice of them being given to her she decided, after due consideration, to take the risks of the radical operation. The operation was not as difficult as he anticipated.

The first step in the operation was to scrape away all cancerous tissue and to sear the remaining surface with Paquelin's cautery. The vagina was then thoroughly cleansed. A stout thread was passed through the cervix to draw down the womb, instead of using a vulsellum, the handles of which would be in the way. A circular incision was made around the cervix and the tissues were stripped up anteriorly and posteriorly to the reflection of the peritoneum, and laterally to the insertion of the

broad ligaments. Finally the peritoneum was opened and the womb retroverted into the vagina by means of the obstetric crotchet passed over the fundus. A strong thread was now passed through the body of the uterus, by means of which to manipulate it more easily. A ligature was now passed around the broad ligament of the right side and secured it *en masse* and a second double ligature was passed through it and tied on opposite side. This side of the broad ligament was then divided, the uterus drawn down and the ligament of the left side secured in a similar manner and divided. The vaginal wound was closed and dressed with iodoform and cotton. A frank peritonitis set in on the third day and proved fatal on the fourth. The result made him doubtful whether the operation is ever justifiable, he indeed felt disposed to avoid it whenever possible.

Dr. E. E. Montgomery inquired about the feasibility of using the galvanic wire ecraseur to divide the broad ligament, keeping the wire at a low red heat and dividing the tissues slowly, and avoiding the necessity for a drainage tube. Another method which he had been revolving in his mind was, by means of the galvanic knife, to dissect out the uterus, leaving the peritoneum intact, thus imitating to a certain extent the operation of Dr. Marion Sims of scraping and the use of zinc chloride.

Dr. Goodell thought that Dr. Montgomery's galvanic wire would get too hot as the loop became small and would then divide rapidly like a knife and incur the danger of secondary hemorrhage. He fears that the steam generated by the hot wire would penetrate the peritoneal cavity and have an irritating effect. He has a galvanic cautery battery, but has not used it since the introduction of Paquelin's benzoline cautery, as he finds the latter more handy and managable. He thinks Dr. M.'s suggestion of shelling out the uterus a very good one.

Removal of the Uterine Appendages for the Relief of Dysmenorrhœa.

Dr. Montgomery exhibited, through the courtesy of Dr. W. H. Warder, the uterine appendages which had been removed from a young lady for the relief of dysmenorrhœa which had resulted in physical and mental failure. Menstruation had commenced at the age of fourteen years, had always been painful and had developed hysterical manifestations. Bathing at the sea-shore had at one time stopped the periods for three months, after this her health failed, her mind had been seriously affected for the last three years, and she would run away or do herself some violence at the menstrual periods if not closely watched.

Examination revealed the uterus enlarged and tender, there was profuse leucorrhœa. The os uteri was dilated and the uterine cavity scraped and cauterized with carbolic acid and bromides, etc., used internally, but no improvement resulted. The ovaries were removed to-day through abdominal section, catgut ligatures were used. The ovaries are very

much enlarged and contain small cysts. The abdominal wound was closed with silk sutures and covered with an impervious dressing of collodion, cotton, etc.

Hystero-epilepsy as a Complication of Pregnancy.

Dr. William H. Shipps of Bordentown, N.J., sent the following contribution.

Briefly defined, hystero-epilepsy is a term applied to an abnormal neurotic condition in which are manifested certain phenomena characteristic both of hysteria and epilepsy. Out of 276 patients confined at La Salpetriere Hospital, Paris, under treatment for various nervous affections 32 were diagnosticated by Beau, a careful observer, as suffering from this disease. Among this number the malady assumed either a distinct or combined form, hence he very wisely groups the cases into two classes. In the first, the hysterial seizures and epileptic fits remain distinct one from the other; to this form he adapts the term given by Landouzy and designates it as hystero-epilepsy with distinct crises.

In the second class, and the one of which this article furnishes an illustration, the hysterical epileptic seizures are coeval, both developing at the same time; to this form the name of hystero-epilepsy with combined crises has been given. The object of this paper is not to enter into a consideration of the disease as it is met with in general practice, but simply to examine it as a complication of pregnancy, a standpoint from which fortunately we are rarely called to view it.

During the early part of March, 1883, I was called to attend a woman said to be in a fit. Arriving at the house, I found, lying on a bed, a young woman apparently seventeen or eighteen years of age, of fairly vigorous physique, who was striving against the united efforts of two or three neighbors who sought to prevent her doing herself bodily harm in the violence of her struggles. Examination showed entire loss of consciousness, eyes open and staring, pupils widely dilated, frothing at the mouth, which was then tightly closed, pulse full and bounding. Inquiry elicited that during the day she had been visiting a friend herself the subject of some spasmodic affection and whilst in her company became greatly exercised on some trivial occurrence and in this state of excitement returned home, which place she no sooner reached than she was seized with a convulsion. Her husband informed me that she was in the third month of pregnancy and that prior to this morning had on one or two occasions attacks somewhat similar though of less severity. I at once injected hypodermatically one-third grain of morphine, which in a short time was followed by a total disappearance of all spasmodic action, a state of stupor supervening, from which, in the course of three or four hours she aroused apparently well as ever. On the day following, I was called to see her and found her in a state of high nervous excitement, sobbing and deploring the presence of some impending danger, which

she, in her imagination, insisted was threatening her. In a short time the stage of muscular contraction, loss of consciousness, stupor, etc., then took place of the hysterical symptoms, finally terminating as before in return to the normal condition.

Without attempting to follow the case step by step, taking in all its details and noting the many and peculiar phases through which it passed, it is interesting to note that prior to September 23, 1883, covering a period of 200 days, not a day passed without the occurrence of one or more paroxysms. At times the hysterical phenomena would be most marked and usher in the attack; then again the epileptic fit would take the precedence, always however accompanied by the undeniable imprint of the dual disease hystero-epilepsy. In the inter-paroxysmal period she enjoyed for the most part average good health.

On the morning of September 23rd, I was asked to see her in an attack of more than usual gravity. When I reached the house she was profoundly unconscious and had been so for several hours. The time for her approaching labor being near, I made a vaginal examination, but found no evidence of commencing uterine action. I ordered a hot mustard bath, mustard to the extremities, and bromides the moment she should be able to swallow. In the evening when I again called her condition was apparently unchanged. I then ordered a blister to the nape of the neck and left the patient, to return in the morning. At 7 a.m., a messenger called, that the woman was now perfectly rational and to all appearance in labor. I at once responded and found that she was having bearing down pains of moderate intensity at intervals of five or ten minutes, mouth of womb dilating, vertex presenting, I remained by the woman's side until 3.45 p.m., when the child, a healthy female weighing 9 or 10 pounds, was born. The labor did not differ from ordinary labor, except that it was only by the utmost vigilance that the woman was prevented falling into one of her accustomed attacks. After the birth of the child, I gave it to the mother, at the same time remarking to her, that as she valued the life of the child, under no circumstances to allow herself to have another convulsion. She promised faithful obedience and up to the present has not shown the first indication of her old trouble. It should be mentioned, that during the entire period the patient was under observation she had daily taken large doses of the bromides and other nervines, without any effect save perhaps in ameliorating the number and violence of the paroxysms. The case is interesting on account of the rarity of the disease as a complication of pregnancy; its persistence throughout the entire period; its resistance to all remedial measures and the final disappearance of all symptoms after the termination of labor.

Two queries very naturally present themselves: What was the exciting

cause of the attacks? Would the induction of premature labor in this and similar cases be justifiable?

In answer to the first query: I attribute the attacks to an action upon the brain and spinal cord, reflex in its nature and developed or excited by the fœtus in utero.

The happy termination of the case would seemingly offer a negative to the second query; but better judgment will, I think, suggest the wisdom of the operation and the danger of refusing to employ what theoretically, at least, offers the only chance of relief; at all events in a similar case I would most certainly have recourse to the operation and expect from it the best results. W. H. H. GITHENS, M.D., Secretary.

BRITISH MEDICAL ASSOCIATION.

Section of Obstetric Medicine.

J. F. Le Page, L.R.C.P. Edin., etc., Durham, read the following paper on

AXIS-TRACTION IN DELIVERY WITH OBSTETRIC FORCEPS.

It is not a little remarkable that so great a diversity of opinion should exist in the profession as to the correct method of using obstetric forceps; and especially it is so when we remember that the foremost champions of each of the various modes are men of great professional reputation—men who are supported by the experience afforded by thousands of parturitions. Nor is it less remarkable that most writers on obstetrics appears to argue, in elucidation of their views, on purely mechanical principles, apparently overlooking the fact that the use of forceps is not a simple matter of art or mechanical dexterity. The delivery of a parturient woman with forceps is an operation demanding considerable skill, but skill resting entirely on scientific principles – an operation which should essentially be an *aid* to Nature when her powers prove insufficient for the performance of her own operations; and the assistance afforded should be at her dictation and on her own lines.

Let me here note in how far authors on obstetrics appear to endeavor to simulate Nature's unerring ways. Dr. Barnes tells us that traction is hardly called for at all; that force is economized by leverage; and that pure traction is impossible (*Lectures on Obstetric Operations*, p. 37). Dr. Smellie advocates traction always from ear to ear. Dr. Leishman enjoins the swaying motion (*System of Midwifery*). Englemann writes: "The oscillating motion antero-posteriorly should not be resorted to, and the less of lateral swaying the better for the maternal parts" (*The Obstetric Forceps*, p. 78). Dr. Edis has recourse almost invariably to a lever pendulum-movement (*Obstet. Trans.*). Gustav Braun says, "The action of the forceps as a lever is a delusion." Dr. Ramsbotham advocates, until the head is born, a slow, waving, pendulum-like sweep from handle to

handle (*Principles and Practice of Obstetric Medicine and Surgery.*) Dr. Playfair says that leverage-action must always be subservient to traction (*System of Midwifery.*) Dr. Simpson directs side-to-side movement. Dr. Milne advises the movement of the handle in a circular direction (*Principles and Practice of Midwifery*, p. 259). Dr. Meadows writes of the efficacy of a slight side-to-side and up-and-down movement, in addition to axis-traction (*Manual of Midwifery*, p. 224.) Dr. Matthews Duncan altogether repudiates lateral traction. Dr. Galabin demonstrates the pendulum-movement with mathematical precision (*Obstetrical Journal*). Notwithstanding that the vaginal walls on both sides have been lacerated and plouged up by leverage-motion, if it can be demonstrated that pendulum, oscillatory, lateral swaying, seesawing, waving, up-and-down, and circular leverages are just imitations of the natural process, then let us oscillate and sway, and so on; or let us resort to any one of these procedures which may be in accord with natural device. But what do we find? We find that, in the wonderful mechanism of parturition, none of these ingenious methods are even suggested. We find that Nature has not found it necessary to adopt any of the rude, but no doubt clever and effective, mechanical contrivances to which I have referred.

The object we have in view is to accomplish delivery, and to accomplish it expeditiously as possible, but with perfect safety to the maternal structures; not to forcibly drag or wedge the head through the maternal parts somehow or anyhow, so long as delivery may be accomplished; but to accurately adapt whatever interference may be necessary to the insufficiency of Nature's abilities in the particular case. I do not mean to argue that these various plans, based on known mechanical principles, are not potent means at our hand for the extraction of a substance through a passage of improportionate calibre; but, when a vital body has to be drawn through a delicate vital passage, powerful levers can scarcely be means adapted both to the end and to the conditions under which they are used.

Now, how does nature accomplish delivery? That is to say, how is the force she uses applied, and what are the effects of that application? The energy developed by the contractions of the uterus, the abdominal muscles, and the diaphragm, is concentrated on the cervical vertebræ of the fœtus; and the effect of this is free movement of the head, whilst it is at the same time subjected to great pressure; so that throughout its entire passage its diameters may be adapted to those of the canal it traverses. Thus the most important movements—flexion, rotation, and extension—are, by the resistance of the pelvic planes, with facility effected. The force is intermittent axis-propulsion; and the intermissions, during which there is little or no pressure on the fœtus, afford it the opportunity of adapting its head to the easiest diameters. I do not mean that fœtal movements take place during every interval of propulsion, but that often

they may be observed, and that they are a part of Nature's plan. If the accoucheur retain his finger in contact with the head during the intervals of pain, he will frequently observe them. After this adjustment of the head, it is again propelled forwards by the uterine effort. We then note that the force is always applied in the same line—that of the spinal column; that great freedom of movement is allowed by the freedom of the head on its axis; and that a little movement during the intervals of propulsion rectifies the relationship of diameters. Are we acting on these lines if we use powerful leverage on the soft parts; or if we forcibly drag the head, with no regard to the adaption of diameters, through the delicate canal of the pelvis? I think not.

In using a tractor, the various movements of the head are no longer guided or controlled by the pelvic planes, but are at the hand, and under the control. of the accoucheur. Therefore a precise knowledge of the exact position and relations of the head is essential; and the traction which is to assist the uterine efforts should be made with a tractor capable of great freedom and range of movement, and the movements of which are unrestricted, and completely under the control of the operator. Having applied the forceps, steady traction should be made in the axis, of course during the uterine contractions; and, never forgetting Blundell's maxim, *arte non vi*, we should proportion the traction to the deficiency of propulsion, so that powerful traction may not be added to the forcible contractions of a strong uterus. Nor should we forget that in not a few cases the office of the forceps is not that of a tractor nor a lever, but little more than that of a compressor. The position and relations of the head, during its whole course, should never be lost sight of, as the alternations in those relations must be assisted—sometimes entirely conducted—by the operator. Whilst traction, during the uterine effort, should always be made in the axis of the part, very gentle rotatory movements should be imparted to the head during the intervals of uterine contraction, to aid its adjustment, and in further imitation of Nature's own method.

If these facts are unmistakable, it is certainly evident that neither the straight nor curved forceps are adapted to the conditions under which they are used. Here then is the *raison d'être* of the instrument I show you. The special characteristics of my instrument are its strong brim and perineal curves, and the adjustable lever. In adaption to the irregular pelvic parabola, the curves are stronger than those of any other forceps. The handle is, nevertheless, in a line parallel with that of the blades, whilst the lever is in a line with the blades. Practically, therefore, it is a straight forceps, but, with the lever, traction can be made backwards in the axis of the brain; and with the use of the lever and handle combined, flexion, rotation and extension may be assisted, or altogether effected by the accoucheur, whilst at the same time the line of

traction is independent and can be continued throughout without any variation from the true axis of the canal.

DISCUSSION.

Mr. Vere G. Webb (Coleshill) said that the principle of axis-traction was essential to delivery by instruments, when the head was at the brim of the pelvis, if one would avoid injury to the maternal structures; and the object to be attained was to find an instrument, as simple as possible, which would always pull in the pelvic axis. There was no question that if the maternal parts could be disregarded, the long straight forceps would be most suitable. He exhibited a pair of forceps, a modification of Sir J. Simpson's long forceps (described in the *British Medical Journal* for October 1881) which would always pull in the proper axis if the operator were careful to pull at right angles to the handle.

Dr. A. Drummond Macdonald (Liverpool) said that since he first had the opportunity of using Simpson's axis-traction forceps, he had paid some attention to this subject, and had also been among the forceps-producers. The axis-traction forceps allowed delivery with much greater ease and less force than the usual form.

Dr. Wallace (Liverpool) remarked that a great deal of ingenuity had been expended in devising modifications of Tarnier's traction-forceps. It was Tarnier's so-called only, for the late Professor Inglis of Aberdeen first devised the treble-curved forceps; and the ingenuity, when tested by practical experience, would be proved to have been in vain. In the course of a prolonged experience of about three hundred cases of forceps-delivery, Dr. Wallace had never found the double-curve long forceps to fail in cases that were really suitable for delivering by long forceps; but he should hesitate to place these forceps in the hands of young practitioners. He showed his students the traction-forceps as a curiosity, but recommended them to get a pair of forceps (Simpson's or Barnes's), become accustomed to the instrument, and stick to it. The traction-forceps in narrow pelvis, in occipito-posterior positions, must prevent rotation completely, and so jam the head and render delivery difficult or impossible. Rectification at the brim could be easily made by the long straight forceps, and the occipito-bregmatic diameter made to engage in the narrow pelvic brim.

Dr. McMillan (Melbourne, Victoria) wished to add his testimony to the value and efficiency of Dr. Simpson's forceps, having had nearly thirty years' experience of that instrument in all kinds of complicated cases. He had found it so simple in its mechanism, and so effective, as to leave nothing to be desired. He was of opinion that discredit had been brought upon Simpson's forceps on account of imitations wanting in the most important points by which Simpson's forceps was distinguished. For example, the blades of these imitations had not sufficient metal in their composition, rendering them too pliant or yielding, so that they

slipped in the hands of the operator. Another important point insisted upon by Dr. Simpson was that the lock should be sufficiently wide to admit of their application even though not in exact apposition. This was the point disregarded by the imitators. These two defects rendered such an instrument almost useless. In Dr. McMillan's opinion, simplicity combined with strength and easy application were the great desiderata; and, above all, the operator should be thoroughly familiar with the instrument, whichever it might be that he had adopted.

Dr. Halliday Croom (Edinburgh) said that he could scarcely believe that either Dr. Wallace or Dr. McMillan had made use of the axis-traction forceps at all. He quite believed that, with the ordinary forceps, delivery could in most cases be easily enough effected. Still, ordinary forceps-cases were made more easy, and there were classes of cases constantly occurring in which delivery with traction-forceps was only used, in which the child's life could be saved. Further, in saving the perineum, in rendering delivery rapid, in dealing with occipito-posterior cases at the brim, the axis traction, especially those of A. R. Simpson, offered an enormous advantage over the ordinary instruments.

Dr. Murphy (Sunderland) had used Tarnier's forceps in between sixty and seventy cases, and had found it most satisfactory in every respect, though Barnes's forceps acted adimirably in the majority of cases.

Mr. Stansfield (Birkenhead), after a considerable experience of forceps-deliveries, found Simpson's or Barnes's to fulfil every requirement. He further pointed out the danger of having forceps scerwed up and made so that they could not be easily separated.

Dr. Walter (Manchester) stated that, in his experience as Obstetric Surgeon to St. Mary's Hospital, he found that occasionally cases did occur of contraction in the antero-posterior diameter, in which one of the ordinary forceps in use, such as Barnes's and Simpson's, was not sufficient to deliver a living child. This was very rarely the case; but, even though it only happened once in fifty deliveries, it were quite sufficient to show that the axis-traction forceps filled a use in obstetrics that should be recognized. The axis-forceps of which Dr. Walter had considerable experience was Aveling's long forceps, and he most strongly recommends them. The forceps shown by Mr. Le Page had a serious drawback in the fact of the blades not being able to be easily and quickly separated, a matter of great importance in preventing continuous compression of the child's head, which, as everyone knew, meant almost certain death to the child.

Dr. Archibald Cameron (Liverpool) did not think that in having forceps with the bent handle, axis-traction was always got. The question was that of a bent lever causing pressure on the walls of the vagina. Something like axis-contraction might be got by hooking on something to the blades near the fenestral line, not by bending the handles.

Dr. Alderson (Hammersmith) said he must bear his testimony as to the efficiency and safety of Simpson's long forceps. He had used them very much, about sixty or seventy times, in 1,500 cases, and always with the best results after he had been sent for by other professional men, and asked to bring his forceps. One particular case he remembered of a lady, primapara, 36, who was most anxious to have a living child. Another medical man was conjointly in attendance; the labor had been long and tedious, the os rigid, and had taken long to dilate—this gentleman had observed that if he used his own forceps, his being straight and broad, he should "split the os." Dr. Alderson said he thought delivery could be speedily and quickly followed by the application of Simpson's long forceps, which he had with him, and by the consent of this gentleman he at once used, and quickly delivered a large and living female child; the lady made an excellent and quick recovery.

The *President* (*Dr. Graily Hewitt*) said that the introduction of axis-traction forceps should draw more attention to the necessity there is of using force in the exact pelvic axis, varying as that did at the levels of of the different pelvic planes.—*British Medical Journal.*

Foreign Gleanings.

TRANSLATIONS FROM THE FRENCH AND GERMAN.

[Prepared for the OBSTETRIC GAZETTE.]

PROF. PARROT, in a series of lectures upon the alimentation of young infants, has pointed to some particulars not generally known in the anatomy and physiology of the digestive tube at that age. In studying the buccal cavity he has shown the uses of the fatty gland of Bichat. This is an oblique elongated mass situated at the junction of the anterior two-thirds and posterior third of the walls of the cheek. It differs materially from the surrounding fat. Increasing up to three years, it diminishes in volume and changes its direction. If the child emaciates under any pathological condition it loses its consistency and returns to its embryonic state. As a result, suction is greatly impeded, it playing an important role in this act. When the infant commences to suckle a vacuum is formed in the buccal cavity, and the internal wall of the cheek presses in to fill it, and it is precisely where this tendency is greatest, above the alveolar arch, that this gland is placed, evidently to facilitate nursing by filling up this vacuum. We must admit that the function made the organ, and that the repetition of the act has caused this particular organic determination. If the function disappeared, after sufficient time the gland would also, as the wisdom teeth have a tendency to disappear, especially in the higher classes.

The normal position of the stomach in infancy is interesting while considering its functions. In the adult its largest diameter is nearly horizontal, in the infant it is almost vertical, showing the still incomplete development of the organ. When the child is held vertically the food accumulates in the large curve, yet passes easily through the pylorus. When placed upon its left sidedigestion is rendered easiest, the food remaining some time in the stomach before passing the pylorus. Placed upon the right side, the food passes almost immediately into the intestine. Placed upon the back with the head thrown a trifle backwards favors regurgitation; and in this position asphyxia may be produced by the introduction of food into the trachea—therefore it is well to hold infants subject to regurgitation in a vertical position for some time after nursing. The gastric juice contains pepsin even in intra-uterine life—the meconium is a product of digestion. The effects of gastric juice differs in the new-born from that in the adult. The child often takes milk up to its last moments, the gastric juice continues to be secreted, and its peptonizing action not being exhausted by death acts upon the walls of the stomach, which are oftener found softened after death than in case of an adult. When there has been a penetration of food into the bronchial tubes, the lungs may be seen partially digested after death. The breasts of the nurse should be well formed, their areolæ of a good color, the mammillary tubercles strongly marked. The glandular element should predominate. The breast of a good nurse differs materially from that seen in statuary. It should be independent of the thoracic walls, its blue veins showing an active circulation. To the touch they are not resistant, but readily admit the fingers among their hard inequalities. Rabelais and Ambrose Paré have remarked upon the disadvantages of the hard resisting breast. The child cannot seize its nipple easily, gets vexed and refuses to nurse. The nipple should be pierced in several places, and be large and cylindrical in form. All emotions of a depressing character should de avoided by the nurse, as deteriorating to the milk. Vogel has discovered the milk to resemble skim milk after an attack of hysteria. Analysis shows it to have lost one-half of its sugar, and an enormous per cent. of its fat. When milk produces convulsions in sucklings it is by the nearly instantaneous change in its composition, and not in any convulsive element that it may have. It may have a peculiar influence upon the digestive tube, for it is only after intestinal trouble that convulsions set in. In light and short febrile attacks lactation need not be interrupted; it often happens that after a long course of fever milk is again secreted. Chapped nipples should be protected while nursing. Nurse every two hours during the day and three times in the night until the third month, every three hours and twice at night to six months, every four hours from that time on. The fecal matter is only fetid when some digestive trouble exists. Normally they ought never to be moulded,

although some habitually constipated children never have soft feces. This constipation is of no consequence when the urine is free and the weight increases. If the urine does not seem sufficient the infant receives too little milk.—*Journal de Médicine Pratique.*

Treatment of Pertussis.—In his new work M. Roger gives the following formula :

Sirop de belladone, 50 grammes.
" de valeriane,
" de digitale, aa 25 grammes.

Dose, according to age and symptoms, of from 5 to 30 grammes during the twenty-four hours. Young infants bear valerian better than ether, which is often substituted for it. It may be given in another syrup or in milk.

When the size of the dose is a matter of consideration the following may be used :

Teinture de belladone, 10 grammes.
" de valeriane,
" de digitale, aa 5 grammes.

For children under two years begin with five drops, increasing five drops each day until thirty drops are reached. From two to five years, begin with ten drops, increasing ten drops every forty-eight hours until sixty drops are reached. For older children, fifteen drops to ninety drops, increasing by fifteen drops every forty-eight hours. Those not wishing to use valerian may substitute the same quantity of musk.

When spasmodic and nervous symptoms predominate from ten to thirty drops of chloroform may be given in the twenty-four hours.—*Jour. de Méd. Pratiques.*

Ovariotomy on a Child of Eight and a Half Years. —The mother had only noticed the abdominal development during a few days. The tumor was movable and slightly fluctuating. The abdomen was opened, the tumor punctured and about a quart of a lemon-colored fluid drawn. The left ovary and Fallopian tube were implicated. No adhesions. Towards the close of the operation artificial respiration was necessary, which lengthened the operation to three hours. Convalescence was rapid and uncomplicated.

Spencer Wells has published one at eight years and another at thirteen years. Péan one at twelve years, the cyst containing hair. M. Ferrier one at thirteen years, the cyst having been punctured several times. All recovered.—*Loire Médicale.*

Vicarious Menstruation.—At six years old the patient received a blow behind the right ear, which was followed by a yellowish discharge, which has since continued. At the age of fourteen she was

awakened one night by pain in the head and sacral region, and a bleeding from the ear, lasting three days. This occurred regular every three weeks. A slight attempt at normal menstruation had showed itself three years previously after a mustard foot-bath and other remedies. It was accompanied, however, by the bleeding from the ear. The ear shows a large perforation, the breasts are poorly developed, no cervix uteri is discoverable, and considerable leucorrhœa exists.—*Progrès Médical.*

Pregnancy and Typhoid Fever.—M. Martinet has made some interesting observations in Siredey's service in Paris. Pregnancy does not influence the course of the fever. Abortion occurs in a little more than half the cases. Abortions occur even in light cases. They are produced from the end of the third week to convalescence. There is no gravity to be attached to them, neither a rise in the temperature or a relapse is to be feared. Puerperal septicemia is unknown. The causes of abortion remain undetermined. Elevated temperature, passive or active uterine congestion and alteration of the blood seemed causes in some but not in all cases. Pregnancy offers no contra-indication to the large doses of quinine treatment.

Triplets.—Mme. Francois, a French midwife, reports a case of triplets. Two head presentations, one breech, three placentæ, three membranes, all boys and in such good condition that they were taken to church to be christened. A year before the mother had a baby and two years previous to that twins. M. Stanton.

Abstracts and Selections.

I.—OBSTETRIC.

Let Nature Remove the Placenta.—In *Deutsch. Med. Woch.*, Sept. 26, 1883, Dr. Dohrn thus sums up his experience:

1. In one thousand lying-in women, in whom the expulsion of the placenta was left to nature, the results were far better than in one thousand others in whom Credé's method of expulsion was used.

2. The one thousand lying-in women in whom the placenta was spontaneousiy expelled, had considerably less hemorrhage and fever after delivery. In those cases treated by Credé's method, portions of the membranes were frequently retained, and there were more fatal cases than in the others.

3. The advantages which are conditional to the method of Créde are especially seen in the cases in which the placenta is expressed during the first five minutes. After a longer time the expression was

more complete, but never as safe as by the spontaneous method.—*Medical Age.*

Influence of Malaria on Pregnancy and the Puerperal State.—Goth, of Klaussembourg, a very malarial place, has had very favorable opportunities for studying this subject. From his observations it seems that:

1. Pregnancy gives no immunity from malarial infection.

2. Malaria predisposes to abortion, and especially to premature labor: it causes premature labor (*a*) by the death of the fœtus, produced either by the high temperature of the mother, or by the direct action of the infecting principle on the fœtal organism; (*b*) by bringing on uterine contractions, MacRunge having demonstrated experimentally that an elevation of the temperature to 40° C. causes uterine contraction. As in all paludal affections and symptoms, quinine is the remedy to be relied on. —*L'Independente.*

Porro-Cæsarean Operation.—Prof. Martino recently performed this operation on a rachitic woman. Strict antisepsis was employed, the operation resulting favorably for both mother and child.—*Revist Clindell. Univ. di Napoli.*

II.—GYNECIC.

Ovariotomy.—The following is taken from a late number of the *Journal of the Am. Med. Ass'n.* It is an editoial and is a good review of the question of the management of the pedicle.

Only a few years ago the operation of ovariotomy by abdominal section was considered one of the most difficult and hazardous of the capital operations. Except in the hands of a few experienced operators the mortality was so great that many were reluctant to admit the operation to the field of practical and legitimate surgery. Now, however, ovariotomy has been so greatly simplified and improved that it is one of the most satisfactory in results of all the more important surgical procedures. While the great change which has been wrought in the status and application of this operation is in great part due to those improvements which have so extended the field of abdominal surgery generally, much is attributable to the improved method of treatment of the pedicle. It is on this feature of the operation—the treatment of the pedicle—that such diversity of opinion and practice has been current, and to which we will direct attention.

When McDowell performed the first ovariotomy in 1809, he secured the pedicle by a ligature, and drew the ends through the lower part of the abdominal incision, leaving them outside in closing the wound. When Dr. Nathan Smith operated in 1821, the vessels of the pedicle were ligatured, the ligatures severed close to the knots, the pedicle returned to

the abdominal cavity, and the wound closed completely. At a more recent date the ecraseur, the actual cautery and the galvano-cautery were used for dividing the pedicle; and the intra-peritoneal method was followed until Mr. Hutchinson, of London, introduced the clamp. By means of this intrument the pedicle was brought out between the lips of the abdominal incision and became extra-peritoneal. This method was at once adopted by Wells in England, and Atlee in America, and has been the popular and most generally accepted method. While Clay, of Manchester, and several well-known German operators adhered to the intra-peritoneal method, the clamp became famous in consequence of the brilliant results of Wells, Atlee and others. In the meantime torsion and Miner's method of enucleation were applied in the treatment of the pedicle, the latter being applicable only to special cases. With the advances steadily made in the various details of the operation by the able workers to whom it was entrusted, the mortality was reduced year by year. Among the noteworthy improvements should be mentioned the influence of the Listerian method of treating wounds upon the success of the operation. The greatest interest, however, continued to center upon the management of the pedicle. It was urged by Mr. Spencer Wells that the pedicle when ligatured and dropped into the abdominal cavity would slough off, thereby leading to a fatal result. In his work on Ovarian Tumors he gave conspicuous place to a fatal case in which an examination revealed the distal portion of the stump attached to a coil of intestine and lying in a pool of pus. The intra-peritoneal method had an able advocate in Dr. Tyler Smith, in England, and a brilliant exponent in Dr. Keith, of Scotland. In America the clamp was adopted very generally. In 1868, Spiegelberg and Waldeyer, of Breslau, made experimental investigations upon the changes which occur in the stump of the pedicle after its ligation and return to the peritoneal cavity.

By these experiments it was shown that the distal end of the stump does not die, but its vitality is maintained through its connecting band underneath the ligature until the sulcus made by the ligature is bridged over with lymph, and vascular connection permanently established. In 1872, Dr. Bantock, of London, exhibited to the Obstetrical Society the stump of an ovarian tumor from a patient who died from cancer one year after double ovariotomy had been performed upon her. On examination the hempen ligature was found to have been almost completely absorbed, the knot only remaining as a hard body about the size of a hemp seed and covered. In a paper recently read before the American Surgical Association, by Dr. J. Ewing Mears and Morris Longstreth, of Philadelphia, the results of extensive experiments upon the lower animals relative to the intra-peritoneal treatment of the pedicle were given. These experiments cover the essential points observed by Spiegelberg and Waldeyer, and demonstrate some important facts bearing upon the choice

of material for ligature. This subject is at the present time under investigation in the hands of Drs. Mears and Longstreth, and additional observations will be reported.

After Dr. Keith, the intra-peritoneal has doubtless been advanced in popularity most by Mr. Lawson Tait, of Birmingham, who has won the highest distinction by his skill in this department of surgery. Adopting almost exclusively the intra-peritoneal method of the ligature cut short, his results are shown in a published table of 101 consecutive cases of ovariotomy with three deaths. Mr. Wells, we believe, still adheres to the clamp, but in America the intra-peritoneal method has been very generally adopted, and the improved results show this to be one of the greatest advances in abdominal surgery. By the clamp the pedicle is drawn out of the wound and exposed to suppurating inflammation. It has been shown that pus is conducted along the pedicle into the abdomen, and thereby begets suppurative peritonitis. It seems that the prediction made some years since by our distinguished countryman, Dr. T. Addis Emmett, that the intra-peritoneal method with the ligature is destined to be the method of the future, is almost verified.

The Indications for Hysterectomy.—By William M. Polk, M.D., in *New York Medical Journal.*

It is a well-established rule in surgery that so desperate an operation as Freund's is now acknowledged to be is not to be performed unless there exists reasonable hope of a permanent cure. In extirpation of the uterus a permanent cure becomes impossible the moment the pelvic glands become infected, they being so placed as to forbid any attempt at their removal. The immense number of lymphatics running from the uterus and their close connection with the pelvic glands make it almost a matter of certainty that in every case of cancer the latter speedily become infected. There is no question but that this implication may exist sometimes before the glands become enough enlarged to be recognized, so that in any given case it would be impossible for one to say with certainty that the disease was confined to the uterus merely because no indurations or enlargements were to be felt in the surrounding tissues.

In uterine cancer, the disease commonly begins at the cervix near the external os, and extends upward as well as outward. If, from the local and general conditions present, we had good reason to believe that the disease was confined to the cervix, and such was actually the case, amputation of the entire cervix, an operation comparatively safe and easy, is all that would be required. Should the disease have extended into the body, it would surely have reached the lymphatic glands, for the tonic required for the former is ample for the latter. Such cases would, therefore, be beyond any curvative treatments, Freunds' or other, palliation being all that is possible.

Touching the few cases of cancer which begin in the uterine body, it is simply a question as to the time of recognition. In the early stages they are regarded as instances of hypertrophy of the mucous membrane with what are called granulation formations; and as such are treated with the curette. Should such a case be recognized as cancer, before there was any decided enlargement of the uterine body, perhaps it would be fair to look upon it as one fit for Freund's operation, for prior to such enlargement the chances of glandular implication are remote. But, cases of primary cancer of the uterine body being comparatively rare, and their early recognition by no means easy, the opportunity for the operation in question, even here, is by no means common.

In sarcoma of the uterus the operation holds a strong position. In this disease glandular infection is far less rapid, the disease remaining localized longer than pure cancer, patients dying as often from septicæmia and pyæmia, resulting from the repeated efforts with the curette, as from the unmolested disease.

A large proportion of these cases can be recognized before glandular infection has occurred, even before there is any decided enlargement of the uterus; consequently, when everything is favorable not only for its operation, but for its early justification and cure. The disease, however, is very rare.

I may sum up by saying that in cancer of the cervix, the common form of uterine carcinoma, Freund's operation is contraindicated; for the disease, is local, can be eradicated by the amputation, if necessary, of the entire cervix, whereas, if glandular infection has occurred, a cure is impossible, palliative measures being then all that are justifiable. From this category I would exclude Freund's procedure, for it is, in my opinion, less useful and far more dangerous than a combination of the many now in vogue. In primary cancer of the body of the uterus it is justifiable, provided the diagnosis be made before glandular infection has occurred; but this is a difficult, and, in some instances, an impossible question to determine, and that too in a rare disease.

In sarcoma of the uterus it is fully justified, and the conditions calling for it can be determined with reasonable certainty, yet the disease is far from common. Consequently, the field open to the operation is very narrow.

A New Operation for the Reduction of Chronic Inversion of the Uterus.— By B. Bernard Browne, M.D., Professor of Diseases of Women in the Woman's Medical College of Baltimore; Fellow of the American Gynæcological Society, etc.

After devoting a considerable amount of time to the study of the different methods of replacing a complete inversion of the uterus of long standing, and appreciating the difficulties and dangers attending the

operations already devised, I concluded to adopt a new procedure in a case which resisted many of the methods referred to.

The simplicity of the operation, and the ease and success with which it was performed, lead me to suggest it as one to be considered in all difficult cases.

The problem to be solved is, how to get the fundus back through the rigid and constricted cervix.

The injuries which frequently result from prolonged taxis, such as rupture of the vagina, rupture of the uterus, peritonitis, etc., are well known. Repeated failures at reduction have occurred to the most skilful operators. Up to this time Thomas's method, which consists in abdominal section over the cervical ring and dilatation from above, has been the only one that could be said to be absolutely sure of accomplishing the replacement in cases which had resisted the other plans—such as the rapid reduction by taxis; Noeggerath's method of indenting one horn of the uterus and reinverting it first; Courty's method of passing two fingers into the rectum and dipping them into the cervical ring, with counter-pressure upon the fundus; Emmet's plan of receiving the fundus in the palm of the hand and spreading the fingers out in the vagina, with counter-pressure from above; or the very excellent and successful method of Dr. J. H. Tate, of Cincinnati, which consists in holding the cervical end of the uterus firmly between two fingers in the rectum and one in the bladder, while the thumbs press upon the fundal extremity.

The patient upon whom I operated presented the following history:

Mrs. I., aged twenty-eight, white, married ten years, has had two children, the youngest six years of age, and has had no miscarriage since. She is a large, stout woman, with thick abdominal walls, weighs about two hundred pounds, and has all the appearance of perfect health. Three months after her last confinement she had a severe hemorrhage from the vagina upon rising in the morning. She lay at the point of death for nine weeks, and since then has been unable to be out of bed for more than two or three weeks at a time, suffering at intervals with hemorrhages, which have lasted from two to four weeks. She has had to be extremely careful in her movements at all times, for fear of bringing on a hemorrhage. Her attending physician has made the diagnosis of "bleeding tumor of the uterus," and offered from time to time to remove it, which, fortunately, was not done.

In March, 1883, she came under my care, and was examined under an anæsthetic. The diagnosis of chronic inversion of the uterus was made. A prolonged effort at reduction by taxis did not succeed in restoring the uterus, but a profuse hemorrhage was excited by the manipulations, and the vagina had to be tamponed with cotton saturated with dilute Monsel's solution. A short time afterward another ineffectual effort at reduction was made. Then continued pressure with Gariel's

air-pessary was resorted to, and used for six weeks, followed at the end of that time by another ineffectual effort at reducion by taxis. In October she came into the Woman's and Child's Hospital, where I made another attempt at reduction, trying Noeggerath's and Courty's methods, but again with failure. The os could be plainly felt through the rectum, but the cervix was so firm and unyielding that it could not be made to dilate.

On November 2d, the bowels and bladder having been evacuated, she was placed under ether, the inverted fundus was drawn outside the vulva with a strong vulsella forceps, the opening of both Fallopian tubes were brought plainly to view, and an incision one inch and a half in length was made through the posterior portion of the uterus (avoiding the Fallopian tubes and larger vessels at the sides of the uterus.) Through this incision Sims' large dilator was passed up into the cervix and expanded to the fullest extent; the rigid tissues of the cervix were felt to relax; then, upon withdrawing this dilator, Nos. 2 and 3 of Hank's hard rubber dilators (three-fourths and one inch in diameter) were passed through the cervix. The finger was also passed to feel that there were no adhesions. The incision in the uterus was then sewed up with carbolized silk-worm gut, and with slight manipulation, the fundus was easily replaced through the now passable constriction.

The whole operation was performed in less than thirty minutes. There was considerable hemorrhage from the uterine cavity when the uterus was first replaced. On the next day the temperature was 102° Fahr., but gradually returned to the normal condition, which it reached on the fourth day. During the first week she complained of severe pain in the uterus, but this was controlled by full doses of opium.

She was placed upon the table and examined on the 14th (twelve days after the operation). The cervix was somewhat patulous, but, with this exception, the parts were all in a normal condition.

Conclusions.

1. This operation is not proposed to supersede ordinary taxis in the reduction of chronic inversion of the uterus.

2. It is not more dangerous, but much more certain, than prolonged or rapid taxis.

3. We avoid the danger of bruising the tissues and rupturing the vagina.

4. As an operation for inversion, it is less dangerous than laparotomy.

5. Unless there be adhesions (which rarely exist), we can always feel certain of reducing the inversion at one operation.—*New York Medical Journal.*

Matthews Duncan on Minor Displacements of the Uterus.—In discussing the relative importance of descent, version, and flexion, he says: "It is,

I believe, universally admitted that versions, flexions, and descent, are not necessarily the cause of any discomfort or disorder, and this is a cardinal fact in this question. Think of it. Thousands of blooming, happy, fertile women have displacements. To treat a displacement, simply because it exists is a grave error, and yet not a rare one." * *

"There is another bad and too common practice which I must not omit to mention here; that is what is called straightening or putting up the womb, or replacing it time after time, by the probe or finger. This has no other effect than to irritate the organ, for the displacement recurs immediately after the probe or finger is removed, as the practice itself shows."—*N. C. Medical Journal.*

Transactions of the St. Louis Obstetrical and Gynecological Society for 1882–83.—This is a neat pamphlet of 121 pages, containing the papers presented to the Society for the past year, and all the discussions thereon.

Some very interesting and instructive papers are included: "Copræmia as a Complication of Labor"; "Removal of Large Fibro-Cyst"; Treatment of Chronic Uterine Affections"; Lacerations of the Cervix"; Management of Abortions," etc.

The discussions appear to be reported verbatim, are practical, and to the point.

This society is evidently doing good work. C. D. P.

One Excuse for Quick Treatment.—One of the Vienna surgeons was one day called in hottest haste to see the little son of a well-known Austrian count. On reaching his patient he found a trifling scratch on the child's hand. Sitting down and writing a prescription he gave it to one of the servants with instructions not to lose an instant, but to bring the medicine as soon as possible. "And is the danger so imminent, then?" asked the countess. "No, not that," replied the Professor; "I only feared lest the wound should be entirely healed before the servant returned.—*Medical Record.*

Remarkable Fecundity.—Dr. F. P. Atkinson writes to the *British Medical Journal* as follows: "I have just come across a somewhat remarkable, well-authenticated instance of fecundity. The lady, who was of good position, married at sixteen years of age and died at sixty-four. She had thirty-nine children (all by the same husband, whom she survived), thirty-two daughters and seven sons, and they were all single births except two, which were twins. An interesting point is that all the children lived to attain their majority."